

Executive Office: P.O. Box 1109 GT, Mary Street, Grand Cayman, Cayman Islands BWI
 Administrative Office: CNA Insurance Companies, P.O. Box 305153, Nashville TN 37230-5153 USA

Insured's Name _____ Policy Number _____

I, _____, Insured/Owner hereby request the CNA International Life Company to change the above numbered policy as follows:

- Reduction in Face Amount** **New Amount:** _____
- Removal of Rider** **Rider Type:** _____
- Other** **Comments:** _____

***The information requested below is not necessary on persons whose benefits are not changing. If the answer to a question is Not Applicable, please indicate this next to each appropriate question.**

The following declarations made by the Insured/Owner are a part of this application:

1. To the best of your knowledge and belief is the Insured disabled? (This question to be answered if the policy includes a disability benefit.) Yes No Not Applicable

2. To the best of your knowledge and belief, has the person(s) whose benefits are changing or who is being added consulted any physician or been hospitalized within the last 5 years other than as admitted on the original application? Yes No

3. Complete additional person information below if coverage is in effect or is being added.

| Full Names of Covered Person(s) | Relationship | Date of Birth | Sex | Height | Weight | Life Insurance In Force | Accidental Death Benefit or Principal Sum |
|---------------------------------|--------------|---------------|-------|--------|--------|-------------------------|---|
| a. _____ | (Insured) | _____ | _____ | _____ | _____ | _____ | _____ |
| b. _____ | (Spouse) | _____ | _____ | _____ | _____ | _____ | _____ |
| c. _____ | | | | | | | |
| d. _____ | | | | | | | |
| e. _____ | | | | | | | |

4. Occupation _____ Duties _____
 Employer _____ Address _____
Street City Country

5. Within the last 5 years, to the best of your knowledge and belief have you or any (proposed) covered person(s) had:

| | Insured | | Add'l Person | |
|--|--------------------------|--------------------------|--------------------------|--------------------------|
| | Yes | No | Yes | No |
| a. Heart attack, heart disease, heart murmur, stroke, high blood pressure, diabetes or kidney disease? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Sugar or albumin in urine? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Tumors or cancer? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Impairment of hearing or vision? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| e. Any mental or physical disorders during the past five years, not listed above? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| f. X-rays, electrocardiograms, blood studies or other diagnostic tests? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

6. To the best of your knowledge and belief have you or any (proposed) covered person(s) been a patient in a hospital, sanitarium or institution or been advised to enter the same for treatment or diagnosis? Yes No Yes No

7. To the best of your knowledge and belief have you or any (proposed) covered person(s) engaged in any type of flying as a pilot or crew member, skin, scuba or skydiving, racing or other hazardous activities within the past five years? (If yes, complete the appropriate Avocation Questionnaire.) Yes No Yes No

8. Have you or the (proposed) covered person(s) smoked a cigarette within the last 12 months? Yes No

9. Beneficiary for: _____
 Additional Person Rider _____

10. Will the coverage applied for replace or change any insurance or annuity in force on the life of any (proposed) covered person(s)? Yes No

If a YES answer is given to any part of questions 1, 2, 5 or 6, give full details including date, names and addresses of doctors consulted.

It is understood and agreed that this application is an amendment to and shall form a part of the application for the above numbered policy, and when accepted by the Company at its Executive Office the application as amended shall form a part of any policy issued hereunder.

Dated at _____ this _____ day of _____ (month, year)
City Country

Witness _____
Broker Insured

Witness _____
Owner

Assignee or Irrevocable Beneficiary, if any

Originating Office _____ G/A Code _____ SA Code _____

Authorization To Obtain Information

I HEREBY AUTHORIZE any physician, medical practitioner, hospital, clinic, other medical or medically related facility, insurance or reinsuring company, the Medical Information Bureau, Inc., consumer reporting agency, or employer, having information available as to diagnosis, treatment and prognosis with respect to any physical or mental condition and/or treatment, including psychiatric conditions, drug or alcohol abuse, and any other medical or non-medical information about me or my health to give to CNA International Life Company or its legal representatives, any and all such information.

To facilitate rapid submission of such information, I authorize all said sources, except MIB, to give such records or knowledge to any agency employed by the Company to collect and transmit such information.

I UNDERSTAND the information obtained by use of this Authorization will be used by CNA International Life Company to determine eligibility for insurance. Any information obtained will not be released by CNA International Life Company to any person or organization EXCEPT to reinsuring companies, the Medical Information Bureau, Inc., or other persons or organizations performing business or legal services in connection with my application, or as may be otherwise lawfully required or as I may further authorize.

I UNDERSTAND that I may request to receive a copy of this Authorization.

I AGREE that a photographic copy of this Authorization shall be as valid as the original.

I ACKNOWLEDGE having received and read the Notice to the Proposed Insured and the Medical Information Bureau Notice.

I AGREE that this Authorization shall remain valid for two years from its date.

X

Proposed Insured 1
(if signing on behalf of Proposed Insured, specify relationship/authority)

Witness Broker

X

Proposed Insured 2/Payor

Date (month, day, year)

LV206-903-B

Agent's Replacement Question

Do you have knowledge or reason to believe that the insurance applied for by this application will replace or change any insurance or annuity currently in force on the life of the proposed insured? Yes No

Date _____

Signed _____
Broker Broker#

Notice To Proposed Insured(s)

Detach—leave with applicant

In order to properly underwrite and administer your insurance coverage we must collect certain necessary and helpful information concerning your insurability. You are our most important source of information, but we must also contact other sources, including medical professionals and institutions, employers, and other insurance companies.

We may obtain an investigative consumer report whereby information as to your character, general reputation, and personal characteristics are secured through personal interviews with your friends, neighbors and others with whom you are acquainted.

In some situations, and in compliance with applicable law, we may disclose necessary items of information to third parties without your specific authorization.

(Please see Notice Regarding Medical Information Bureau.)
Thank you for your application for insurance .

LV206-274-B

Notice Regarding Medical Information Bureau

Please Read Carefully

Information regarding your insurability will be treated as confidential. CNA International Life Company or their reinsurer(s) may, however, make a brief report to the Medical Information Bureau, a nonprofit membership organization of life insurance companies, which operates an information exchange on behalf of its members. If you apply to another Bureau member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, the Bureau, upon request, will supply such company with the information in its file.

CNA International Life Company or their reinsurer(s) may also make information in its file available to other life insurance companies to whom you may apply for life or health insurance, or to whom you submit a claim for benefits.

Upon receipt of a request from you, the Bureau will arrange disclosure of any information it may have in your file. If you question the accuracy of information in the Bureau's file, you may contact the Bureau and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of the Bureau's information office is Post Office Box 105, Essex Station, Boston, Massachusetts 02112 USA.

LV203-902-A